AND

3. Complete training in a case management curriculum approved by the State Health and Human Services Finance Commission.

F. Free Choice of Providers

All children age 0-21, eligible for Medicaid and who are placed in the custody of the state will be eligible to receive these case management services.

The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.

2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Services for children who are insured by a third party payor which covers the cost of case management will be reimbursed by the third party payor. Title XIX funds will be used when a child has no third party coverage and is eligible for Medicaid. The few remaining children will have their case management services funded by Title IV-B.

19. CASE MANAGEMENT - Individuals with Head and Spinal Cord Injuries and Related Disabilities

Under the authority of Section 1915 (g)(1) of the Social Security Act, case management services will be covered without regard to requirements of section 1901(a)(10) of the act and will be targeted to individuals with head and spinal cord injury.

A. Coverage is limited to non-institutionalized Medicaid recipients determined to have a head and spinal cord injury or related disability.

B. Case management for clients with head and spinal cord injury or related disability is not restricted geographically, and is provided on a statewide basis in accordance with section 1902(a)(1).

C. All case management services for this targeted Medicaid population are comparable in amount, duration and scope.

D. DEFINITION OF SERVICES:

Case management services are defined as those services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services. Service Plan/Needs Assessment will be provided to identify the individual's need for case management. Service needs and resources identified will be coordinated and integrated. A mechanism for referral will exist as an integral part of this service, including a process for follow-up monitoring and tracking.

Case management for Medicaid clients with head and spinal cord injury or a related disability will enable the recipients to have timely access to care and programs that are appropriate for their needs. The service plan will be developed in conjunction with the recipient/family and will be based on mutually determined goals. Adequate records will be maintained to ensure that the services deemed necessary were actually utilized.

E. Qualification of Providers:

Provider entities must demonstrate the capacity to provide all core elements of case management services to individuals with head and spinal cord injuries and related disabilities. Individual case managers must hold a Master's or Bachelor's degree in Social Work or a related field OR a Bachelor's degree in an unrelated field of study **and** have 1 year of experience working with individuals with head and spinal cord injury or related disabilities, or in a case management program.

F. Free Choice of Providers:

Case management services to Medicaid patients with Head and Spinal Cord Injuries will comply with CFR Regulation regarding Freedom of Choice. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the right to change or terminate case managers if and when they desire.

2. Eligible recipients will have free choice of providers of other medical care under the state plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other programs authorized for this same purpose. The Head and Spinal Cord case management must not duplicate any other Medicaid case management or waivered service.

Case Management - Individuals with sensory impairment.

Under the authority of Section 1915 (g) (1) of the Social Security Act, case management services will be covered without regard to the requirements of Section 1902 (a) (10) (B) of the act and will be targeted case management for sensory impaired individuals.

A. Coverage is limited to non-institutionalized Medicaid recipients determined to be sensory impaired. Additional criteria is listed as follows:

(1) diagnosed as legally blind or visually impaired, or deaf or hard of hearing or multi-handicapped by a qualified specialist in the areas of vision and hearing.

(2) eligible for services as determined by criteria established by South Carolina Commission for the Blind or South Carolina School for the Deaf and Blind or be an applicant in the intake process.

(3) between the ages of birth through sixty-four (64) years of age at the time of application.

(4) a resident of South Carolina.

(5) a Medicaid recipient.

B. Case management for the sensory impaired population is not restricted geographically, and is provided on a statewide basis in accordance with section 1902 (a) (10) (B).

C. All case management services for this targeted sensory impaired population are comparable in amount, duration and scope.

D. **Definition of Services:**

Case management services are defined as those services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. Case management components are intake/assessment, care coordination and intervention. Assessments will be provided to identify the individual's need for case management. Service needs and resources identified will be coordinated and integrated. A mechanism for referral will exist as an integral part of this service, including a process for follow-up monitoring and tracking.

Case management services for the sensory impaired population will enable the recipients to have timely access to care and programs that are appropriate for their needs. The plan of care is developed in conjunction with recipient/family and are based on mutually determined goals. The case manager must maintain adequate records to ensure that the approved plan of care and all services that were deemed necessary were actually utilized. A plan of care will be reviewed at least on a semi-annual basis to assure that needed services were accessed.

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RO APPROVAL: JUN 16 1993
SUPERSEDES: N/A

E. **Qualifications of Providers:**

Individual case managers serving this target population must, at a minimum, hold a master's degree in human services (social or behavioral), allied health, or special education field and one (1) year experience performing rehabilitation, clinical or casework activities, preferably with sensory impaired individuals; or a bachelor's degree in the above and (3) years experience in performing rehabilitation, clinical or casework activities, or a bachelor's degree with a combination of education and experience listed above. The case manager must successfully complete the established training curriculum for case management of sensory impaired children.

F. **Free Choice of Providers:**

All sensory impaired individuals birth through sixty-four years of age who are eligible for Medicaid are eligible to receive these case management services.

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible recipients will have free choice of case managers and the freedom to switch case managers if and when they desire.

2. Eligible recipients will have free choice of providers of other medical care under the State Plan. Case managers will assure that freedom of choice of physicians and other medical care providers is maintained at all times.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. The case management will not duplicate any other Medicaid case management or waivered service.

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20.a Extended Services To Pregnant Women
&
20.b In an effort to improve access and a continuum of care for pregnant women, the following measures have been implemented. All services are available to all pregnant women and their infants to ensure early and adequate access to prenatal care, a medical home, health education, nutritional counseling, follow-up for compliance with social, medical and home environmental assessment and counseling.

Available Services:

A. Risk Assessment

All pregnant women must be evaluated for medical risks at the earliest possible time after confirmation of pregnancy. The assessment is in addition to the initial maternal care examination. The State Health and Human Services Finance Commission (SHHSFC) Form 204 must be completed and submitted by any enrolled medical provider (physician, clinic, hospital, etc.). A subsequent assessment is appropriate if and when the patient's risk status changes.

Another risk assessment is allowed for the infant and should be completed as soon after birth as possible.

A risk assessment is the "gateway" service that determines whether the patient is medically high risk. It is the determinant of whether the patient should be channelled into high risk services (HRCP) or be offered other non-high risk services (e.g., "at risk", "non-high risk", or "low risk" case management).

B. Healthy Mothers/Healthy Futures Program

To encourage appropriate access and adequate medical care, all pregnant women may receive enhanced educational and referral services. All Primary Care providers enrolled may render and bill for delivery of the enhanced services as published in the Healthy Mothers/Healthy Futures Program.

Providers who participate in the Healthy Mothers/Healthy Futures program may bill using enhanced service codes which reflect the following services:

- Initial Maternal Care - This service takes place in a medical setting at the initial maternal visit. During this exam, the patient receives standard medical services from a physician including a physical examination, medical history and laboratory tests. The physician seeks to identify problems that may jeopardize birth outcomes. It includes health education, referral to Women, Infant and Children (WIC) and to any additional services considered appropriate. Reimbursement for this service is based only on referral, not on whether the patient chooses to pursue the services provided by these referrals. It is expected that the medical provider will inquire as to whether the patient pursued the referrals.

- Antepartum Exam With Additional Services - This service involves follow-up to determine whether the patient has chosen to pursue referrals and follow-up on missed appointments.

- Postpartum Care With Additional Services - This service includes referral for family planning, referral to WIC and parenting education. Reimbursement is not based on the patient's acceptance of a family planning method.

C. Post Partum Home Visit

The postpartum home visit is provided by a nurse and focuses on the mother within 14 days after delivery by identifying postpartum needs of the patient.

Postpartum home visit providers will:

- perform a medical assessment of the postpartum mother;
- assess household components and environment to determine barriers to health;
- provide health education regarding postpartum recovery and family planning; and
- assist the family in establishing a primary source of care and a primary care physician (i.e., ensure that the mother has a postpartum visit scheduled).

D. Enhanced Services

All non-high risk pregnant women are eligible for nutrition, health education and psycho-social assessments to determine factors that may negatively impact birth outcomes. If appropriate and deemed necessary after the evaluation, all pregnant women may receive nutrition and educational services in addition to psycho-social counseling. All appropriate referrals for treatment are covered if the patient is referred to an approved provider.

These services include the following:

1. Psycho-Social Intervention (PSI) - Assessment and treatment provided to maternity patients through face-to-face encounters. The assessment identifies psycho-social factors (e.g., spouse abuse, co-dependency, etc.) that may negatively impact the pregnancy and birth outcome. Problems that are identified by the assessment will be addressed through psycho-social follow-up/treatment services provided on an individual basis and based on a plan of care. These services may be provided in the clinic, home or other appropriate settings.

   Appropriate Provider Staff: Must have master of social work degree or Bachelor of Social Work Degree, licensed as LMSW, LISW, or LBSW by the South Carolina Board of Social Work Examiners. The LBSW must be under the supervision of a masters level social worker (LMSW, LISW).

2. Nutritional Services - Assessment and treatment provided to referred maternity patients in the clinic or home through face-to-face encounters. The goal of nutrition services is to promote health by achieving and maintaining optimal nutritional status throughout the pregnancy. Nutrition services are an integral part of all health care. Conditions during the pregnancy which frequently necessitate referral include patients who are underweight/overweight or have low iron stores. A comprehensive nutritional assessment will be completed on any low risk maternity patient who is referred to a nutritionist. Prenatals should receive this nutritional service in such a timely manner that the greatest benefit from this service will be realized (e.g., early in gestation). The nutritional assessment must be in addition to the required WIC food frequency and nutrition education encounters. Nutrition follow-up/treatment is provided on an individual basis, based on a treatment plan.

   Appropriate Provider Staff: Nutritionist with Master's Degree in Public Health Nutrition, Community Nutrition, Dietetics or a related field; or a Bachelor's Degree in Public Health Nutrition, Community Nutrition, Dietetics or related field; or a Bachelor's Degree and successful completion of a dietetic internship or a coordinated undergraduate program in dietetics.

3. Health Education - Information and process oriented activities provided on an individual or group basis. These services are based upon individual needs assessments and are designed to predispose, enable or reinforce the voluntary adaptation of behavior by the pregnant woman that is conducive to health and positive birth outcomes. Examples: parenting, smoking cessation, alcohol and other drug effects. Health education services will be provided in accordance with published guidelines, which include SHHSFC approval of curricula and providers.

   Health Education Visits - Visits accommodate the need for confidential discussion, scheduling convenience and other learner needs.

   Collaborative Group Instruction is learning through collaboration and involves at least three learners. Focused interaction is the essential element of this type of health education service.

   Informational Group Instruction allows and encourages interaction between learners; however, the primary focus is to distribute essential information in an attractive and stimulating format.

   Appropriate Provider Staff: Health Education Specialist, Health educator I, II, and III or appropriate designees (medical, nursing and allied health professionals).

E. Family Planning

Family planning services should be an integral part of the medical and social care of the Medicaid eligible pregnant woman and parent of a newborn infant. The patient should be encouraged to seek and adhere to a family planning program of her choice. Family planning services are documented in the appropriate Medicaid Provider Manuals.

Existing family planning services focus on physical examinations to determine the appropriateness of a birth control method and the dispensing of the method (e.g., birth control pills, condoms). The enhanced family planning services provide for counseling and education to help pregnant women a) plan for their postpartum birth control method; b) make informed decisions regarding sterilization; and c) become aware of the potential health hazards of another pregnancy before the body has had time to heal from the current one. Existing family planning codes are not reimbursable at rates that include a provider's cost for the additional staff time to provide intensive counseling and education components. These enhanced services assure that the patient receives the vital information by accommodating the additional cost. The patient's freedom of choice for family planning services and/or family planning providers will not be restricted.

F. General Maternal Care

Antepartum and postpartum examinations are unlimited and not restricted by the Ambulatory Care visit limitations. All medical services including laboratory and x-ray are provided as medically indicated without limitations.

24.a <u>Transportation Services</u>

A. Ambulance services must be medically necessary. Medical necessity has been established by SCDHHS to be when the recipient's condition is such that use of any other method of transportation is contra-indicated. In any case in which some means of transportation other than an ambulance could be utilized without endangering the recipient's health, whether or not such transportation is actually available, no payment may be made for ambulance service.

Non-covered Services

1. Routine service to or from a physician's office.

2. Service for ambulatory recipients whose illness or injury does not justify medical necessity.

3. If the recipient was pronounced dead at the scene by authorized personnel; i.e., coroner, M.D., etc.

4. Service to or from a hospital outpatient department for regularly scheduled treatment.

5. Service to or from a nursing facility to a hospital outpatient department for routine medical services.

6. Service from a hospital to a nursing facility which is out of the locality of the hospital.

NOTE: Exceptions to all of the above will be reimbursed only if the documented diagnosis, medical necessity, and circumstances adequately justify the services.

B. Other Transportation Services

Where transportation is not available free of charge, when prior approved by the County Director, payment will be made to common carrier, CAP agencies, volunteers, and taxi services for covered Medicaid (Title XIX) sponsored benefits.

Prior approval from the State Office is required for individual medical transportation outside a 25 mile radius of South Carolina.

24.d NURSING FACILITY SERVICES (FOR PATIENTS UNDER 21 YEARS OF AGE). Prior approval for admission (or upon request for payment) and/or prior approval for resident case mix classification as appropriate is the responsibility of the Division of Community Long Term Care, SCDHHS. Annual validation of resident case mix clarification based upon a random sample of 20% of facility residents shall be performed for SCDHHS, under contract by DHEC. Includes services provided in a swing bed hospital. Includes subacute care provided to ventilator dependent patients when contracted to provide this care (effective 04/01/89).

Basic services and items furnished in a nursing facility that are included in the per diem rate and must not be charged to the patient include the following:

A. Nursing Services - Includes all nursing services to meet the total needs of the resident, the administration of treatments and medications as ordered by the physician, assistance with mobility (walking and wheelchair), and routine nursing supplies. Nursing supplies include, but are not limited to such items as syringes, air mattresses, I.V. supplies, adhesive tape, canes, ice bags, crutches, glycerine, mouth swabs, water pitchers, bed pans, thermometers and urinals.

B. Special Services - Including assistance by the facility social worker, participation in planned activities, physical therapy, speech therapy, occupational therapy and inhalation therapy.

C. Personal Services - Services for the comfort of the resident which include assistance with eating, dressing, toilet functions, baths, brushing teeth, washing and combing hair, shaving and other services necessary to maintain a clean, well kept personal appearance. Includes assistance with walking and wheelchair use when necessary. Diapers and underpads are provided as needed.

D. Room and Board - Includes a semiprivate or ward accommodations, all meals including special diets and snacks ordered by the physician. Includes feeding residents if unable to feed themselves and tube feedings. Housekeeping services and bed and bath linens are included.

E. Safety and Treatment Equipment - Including, but not limited to the following items: standard wheelchairs, infusion equipment, bedside commode, side rails, restraint chairs (Geri-chairs), suction apparatus, walkers, crutches, canes and other equipment that is generally used by multiple residents and does not become the property of the individual resident.

F. Medications - Over-the-counter (OTC) non-legend medications are included (except for insulin). The resident may receive up to three prescriptions per month which are covered by Medicaid. If the drugs are obtained from a pharmacy which participates in the Alternate Reimbursement Methodology Plan, the resident is not required to pay for prescription drugs that meet the program guidelines even if the number of prescriptions is greater than three.